COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
DEPARTMENT FOR EMPLOYEE INSURANCE

2008/2009 HEALTH INSURANCE UPDATE FORM

Do NOT use this form to add or drop dependents. Insurance Coordinator complete form.

GENERAL INFORMATION (*REQUIRED*)

SOCIAL SECURITY NUMBER	COMPANY NUMBER
NAME	COMPANY NAME

TERMINATION:

DATE EMPLOYMENT ENDS_____ DATE INSURANCE TERMINATES_____

Reason: Resigned Retired LWOP Death Military Other_____

REINSTATE:

DATE RETURNED TO WORK _____ DATE INSURANCE EFFECTIVE _____

Reason: Rehired FMLA LWOP Military Other_____

TRANSFER

- ***To be completed by the <u>NEW</u> company***
- ***No changes to current coverage are allowed on this form***

PRIOR COMPANY #_____	NEW COMPANY #_____
LAST DATE WORKED AT PRIOR COMPANY_____ __	DATE HIRED AT NEW COMPANY_____
COVERAGE END DATE FROM PRIOR COMPANY #_____	COVERAGE BEGIN DATE AT NEW COMPANY #_____

OTHER CHANGES OR CORRECTIONS FOR SELF ☐ SPOUSE ☐ CHILD ☐

NAME **NEW** _____

PREVIOUS _____

NEW ADDRESS (where mail received)_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

EMAIL: _____

SSN **CORRECT**_____ **INCORRECT** _____

DATE OF BIRTH _____ **OTHER** _____

EMPLOYEE SIGNATURE	DATE	COORDINATOR SIGNATURE	DATE

Insurance Coordinator: Mail this form to DEI, 501 High St., 2nd Floor, Frankfort, KY 40601